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Executive Summary

7.3.1.1.3.1. Overview
Incorporated in 1995, Behavioral Health Link has operated mobile crisis teams since 2002 in the State of Georgia. We currently provide mobile crisis response services in 104 Georgia counties for adults and children with crises related to mental health substance use and developmental disabilities 24/7/365 under contract with the Georgia Department of Behavioral Health and Developmental Disabilities. We respond primarily to residences but will respond wherever the crisis is located. We serve very rural areas as well as urban areas including the city of Atlanta.

7.3.1.1.3.2. Understanding of Solutions and Anticipated Problems
The Department of Health and Human Services, Division for Behavioral Health of New Hampshire supports a crisis system that is responsive to the needs of individuals and families affected by behavioral health issues. The development of an integrated statewide emergency services and mobile crisis response system is expected to reduce the number of psychiatric patients waiting in hospital emergency rooms for behavioral health treatment and will provide an alternative mechanism to engage people in appropriate levels of care. The Department intends to develop an efficient and sustainable statewide crisis response model to serve adults and children.

There are nationwide challenges with workforce in each of these disciplines and the volume of crises related to children and youth fluctuates significantly around the school calendar with volume being the lowest in the summer and during holidays. Mobile Crisis should be 24/7/365.

7.3.1.1.3.3. Overall Design
Georgia operates mobile crisis as a separate entity and not operated by any single community mental health agency. When mobile crisis is operated by a separate and distinct entity, individuals in crisis receive services whether they are enrolled in care or not. It is optimal for providers to serve their own individuals when they are in crisis and in most systems the provider can bill for that service. If an enrolled individual interfaces with a mobile crisis team, it is crucial the team reconnects the individual to services if that is what the person in crisis chooses.

It is also important that the there is adequate capacity for rapid response and that mobile crisis staff are not dedicated to any other services. Between calls, these teams should be building relationships with first responders, emergency departments and providers. Hosting quarterly crisis collaboratives in service areas where they discuss pain points in the system, data, performance and talk through challenging situations to problem-solve solutions is imperative.

7.3.1.1.3.4. Respondent's Familiarity and Solutions Presented
Behavioral Health Link has operated mobile crisis teams since 2002 in the State of Georgia. We currently provide mobile crisis response services in 104 Georgia counties for adults and children with crises related to mental health substance use and developmental disabilities 24/7/365 under contract with the Georgia Department of Behavioral Health and Developmental Disabilities.

We believe youth only focused teams would sit idle too often and that has been the case with specialty teams for developmental disabilities. Having well-trained crisis staff prepared to handle crisis across the lifespan and across disabilities has proved beneficial and provides efficiencies and an economy of scale for a very crucial service. As these teams become more experienced, they become more proficient with different populations and more effective overall. They also build solid relationships with the communities they serve and have become a vital part of the emergency response landscape as they work in tandem with emergency services, emergency departments, providers and community supports.

We recommend that the state review the number of licensed clinicians who live in the counties served carefully before determining licensure requirements and response time requirements. It must be realistic based on workforce and capacity. While an hour seems to be a "gold standard" many states have made allowances for terrain and there is a paucity of research related to whether there is a true clinical difference between 60 and 90 minutes.

7.3.1.1.4. Answers to RFI Questions

Q1. Briefly describe your organization, who you serve, and any experience/expertise specific to behavioral health crisis response services. Please keep generalized marketing material to a minimum.

Incorporated in 1995, Behavioral Health Link has operated mobile crisis teams since 2002 in the State of Georgia. We currently provide mobile crisis response services in 104 Georgia counties for adults and children with crises related to mental health substance use and developmental disabilities 24/7/365 under contract with the Georgia Department of Behavioral Health and Developmental Disabilities. We respond primarily to residences but will respond wherever the crisis is located. We serve very rural areas as well as urban areas including the city of Atlanta.

Q2. Describe any experience/expertise or lessons learned operating mobile crisis response services and/or statewide integrated teams specific to the Factors to Consider listed in Section 4.

In our experience, it has never made sense to have separate teams for adults and youth. For a long period of time we also had separate teams for individuals experiencing crises related to developmental disabilities, but in January of 2019 we went to blended teams responsible for serving adults and children with mental health substance use and or crises related to developmental disabilities and autism.

There are nationwide challenges with workforce in each of these disciplines and the volume of crises related to children and youth fluctuates significantly around the school calendar with volume being the lowest in the summer and during holidays. We believe youth only focused teams would sit idle too often and that has been the case with specialty teams for developmental disabilities. Having well-trained crisis staff prepared to handle crisis across the lifespan and across disabilities has proved beneficial and provides efficiencies and an economy of scale for a very crucial service. As these teams become more experienced, they become more proficient with different populations and more effective overall. They also build solid relationships with the communities they serve and have become a vital part of the emergency response landscape as they work in tandem with emergency services, emergency departments, providers and community supports.

We do recommend that responses to residences require a two- person response for safety purposes but believe responses to schools, jails, and emergency departments (safe, staffed sites) can safely benefit from one responder. In Georgia currently two responders are required for all responses, but we believe it is not necessary and can unnecessarily delay response time. Of course, responding to the emergency department is a last resort if the individual has already made their way that far upstream. When functioning optimally in tandem with a robust crisis and access line (call center hub) these teams can make a significant impact on ER utilization. Less than 5% of individuals seen by our teams in the community end up in emergency departments and when they do it is because of a legitimate medical concern.

Mobile Crisis should be 24/7/365. We would recommend the state considers varying response time requirements based on the terrain. We find in rural areas our teams are driving 70-80 miles on average to calls and it is not possible to do that in an hour. Teams in more urban areas are better able to meet

60 minute response times and often less. We have not seen any literature that demonstrates a 90 minute response time is detrimental. If the individual needs care in less than 90 minutes, it is often the case that active rescue with EMS is necessary. Though active rescue only accounts for roughly 2% of cases triaged by our crisis and access line (call center hub), these situations should be sent to 911 immediately due to the imminent risk. It is appropriate for the mobile team to attempt co-response but unless mobile teams are considered first responders which they are not, expecting mobile teams to arrive immediately in these cases is not feasible and would require capacity well beyond what even mobile teams with robust funding and 1- hour response times can provide.

We recommend that the state review the number of licensed clinicians who live in the counties served carefully before determining licensure requirements and response time requirements. It must be realistic based on workforce and capacity. While an hour seems to be a "gold standard" many states have made allowances for terrain and there is a paucity of research related to whether there is a true clinical difference between 60 and 90 minutes.

Q3. Provide your recommended approach(s) for the provision of statewide mobile crisis response services. This could include a model for an integrated crisis continuum and should specifically indicate if services are proposed to be operated by a stand-alone entity or integrated into designated community mental health programs as a part of the continuum of crisis care. Specifically, how will the recommended model enhance, augment, strengthen, and/or expand existing resources?

We recommend a system like Georgia operates currently where mobile crisis is a separate entity and not operated by any single community mental health agency. In our opinion, the challenge with a community mental health operated approach is this design does not foster easy access for individuals who are currently unenrolled with the behavioral health system or who have fallen off the roll of local centers. Some states have struggled with community mental health attached mobile crisis teams refusing to see individuals "unknown" to the system. When mobile crisis is operated by a separate and distinct entity, individuals in crisis receive services whether they are enrolled in care or not. It is optimal for providers to serve their own individuals when they are in crisis and in most systems the provider can bill for that service. If by chance an enrolled individual interfaces with a mobile crisis team, it is crucial the team reconnects the individual to services if that is what the person in crisis chooses.

It is also important that the there is adequate capacity for rapid response and that mobile crisis staff are not dedicated to any other services. In our experience, between calls, these teams should be building relationships with first responders, emergency departments and providers. Our teams host quarterly crisis collaboratives in their service areas where they discuss pain points in the system, data, performance and talk through challenging situations to problem-solve solutions.

Safety and Mobile Crisis many states have struggled with teams being unwilling to see those unknown to the system citing safety concerns. As a stand-alone mobile crisis entity, thought safety of paramount, we have a no-refusal policy. Once the crisis and access line (call center hub) has screened the referral and recommended mobile crisis the team responds period.

Out of Home Placement Diversion Hospital diversion is one of BHL's chief goals and our overall diversion rate over 63,000 dispatches is over 77%! It is woven into the fabric of our Mobile Crisis Teams and our Crisis Call Center services as a function of its core business on public sector integrated crisis intervention. There are other agencies in Georgia for example who provide Out-of-Clinic Crisis Assessment services (mostly in emergency rooms), but their business models are different and they have a different set of objectives as a result.

- Community Mental Health Centers have a bias toward clinic-based assessment and dispatch to emergency rooms as necessary. Hospital diversion may be a secondary goal.
- Private psychiatric assessment teams operate on the behalf of inpatient units and therefore measure "Conversion Rate," which is the percentage of individuals who are converted to inpatient status (the opposite approach of hospital diversion).
- Emergency rooms measure the time a patient occupies a bed and work to obtain the fastest disposition, creating capacity for individuals with medical emergencies.

BHL Mobile Crisis values hospital diversion as a primary goal and table above demonstrates the phenomenal results that have been achieved in Georgia since 2002. BHL staff believes this is a recovery-based goal, in that self-directed care in the least restrictive setting leads to the most powerful outcomes. BHL staff will limit invasive interventions such as hospitalization to those situations where it is truly required. They ensure costly intensive inpatient services are available to those who need them, and that there are not delays in access or problems with quality due to an influx of individuals who could have been served more effectively with lower levels of care.

BHL's hospital diversion success is based on a few key elements. First, BHL's work is not complicated by potentially conflicting goals of other business models. Second, BHL works to provide an intervention as far upstream as possible (see continuum at left). Third, BHL staff spends a significant amount of time in crisis intervention, collaborating, providing de-escalation, and engaging natural supports, such as family.

In 2002, Hugo, Smout and Bannister in the Australian and New Zealand Journal of Psychiatry studied the difference between hospitalization rates comparing a community-based mobile emergency service and a hospital ER-based emergency service. They concluded, "Hospital-based emergency service contacts were found to be more than three times as likely to be admitted to a psychiatric inpatient unit when compared with those using a mobile community-based emergency service, regardless of their clinical characteristics." These findings coincide with BHL's data and experience that there are increased challenges to diverting individuals from state hospitals once they are evaluated at an emergency room.

BHL utilizes a metaphor of intervening "upstream" to achieve optimal self-directed, recovery-based outcomes. Whereas the ER is the last stop before the falls on the stream of crisis intervention, engagement with law enforcement also increases the likelihood of hospitalization (and incarceration). In Roger Scott's 2000 study published in Psychiatric Services, entitled, "Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency and Consumer Satisfaction," the conclusion stated, "Fifty-five percent of the emergencies handled by the mobile crisis team were managed without psychiatric

hospitalization…, compared with 28 percent of the emergencies handled by regular police intervention, a statistically significant difference."

As a result, our approach is to engage individuals in their natural settings far upstream from law enforcement, emergency rooms and state hospitals. Research shows that the force of the current in this stream gains a significant momentum as one floats closer to the falls over into state hospital admission or incarceration. This pressure is based on other dynamics than the clinical presentation of the individual in crisis

Reducing ER & Law Enforcement Contacts According to the National Hospital Ambulatory Medical Care Survey 2009, trips to emergency departments for behavioral health issues increased 14% between 2008 and 2009 alone and more recent data has mirrored this result. These results that are not surprising to any of us working in Behavioral Health, but the statistics are alarming nonetheless. This is clearly a tremendous financial burden on emergency departments, but the human cost is very difficult to calculate. It is clear however that individuals of similar acuity assessed in emergency departments are three times more likely to be hospitalized than those assessed in the community.

There are many positive benefits from engaging individuals in crisis in their natural settings as opposed to waiting until they are in more restrictive environments "downstream." This is why we work closely with the community for customized solutions to community issues. We welcome the opportunity to work with communities like we have in the city of Atlanta with our Grady project to do everything possible to avoid unnecessary law enforcement and emergency department intervention. The more we educate the community on the availability of GCAL and mobile crisis services, the more we can divert individuals in crisis from these costly and often unnecessary services.

If individuals do get to the ER, we will work diligently to build the trust necessary with ER physicians to rescind unnecessary involuntary orders. In our experience, when they are confident that the team will follow up and ensure the individual will get the care he or she needs, they are more likely to follow the team recommendations. We have found that the less restrictive the assessment setting the less restrictive the disposition.

Community Response Leads to the Least Restrictive Level of Care Research is clear that individuals who are assessed in the ED when compared to individuals of the same acuity who are assessed at home have a much greater chance of being hospitalized. Private psychiatric teams assess individuals almost exclusively in emergency departments and occasionally clinics. Our approach is very different. We prefer to see individuals in their own environment and find this makes the process much more pleasant for the consumer, as it gives him/her a sense of control of a situation that is often very out of control during crisis. As honest brokers we help identify the level of care necessary for the situation but whenever possible we want to give individuals choice about who will provide their urgent or ongoing care.

We believe serving the population with Severe and Persistent Mental Illness (SPMI) and those with IDD and Autism Spectrum Disorder should be rooted in self-directed care and bolstered by recovery principles is not compatible with the bottom line of these teams and thus presents a barrier to

individuals receiving the benefit of care in the least restrictive environment and a direct conflict of interest when it comes to stewardship of public funds potentially used to purchase beds at these facilities.

Experts in Community Response BHL's MCRS have unmatched experience in responding to crises outside of emergency departments in Georgia. Below are the percentages of Community Responses (mobile crisis interventions outside the emergency department) for the last 5 years.

Year	Percentage of BHL Mobile Responses Outside the Emergency Department
2014	78%
2015	81%
2016	87%
2017	87%
2018	88%

Community Mental Health Teams Teams operated by Community Service Boards, in our experience, focus almost exclusively on emergency department intervention and often have very strict criteria that need to be met prior to response. Community Service Boards and other Core Providers can also use crisis response to optimize their payer mix to their financial advantage, we believe this can cause barriers to access for individuals in great need.

With the benefit of our experience, we see MCRS as a program that is designed to ensure the right level of care and to save lives. It is not meant to be a means to exclude individuals from services. Regardless of an individual's status as insured, uninsured, all individuals in crisis are at risk for death by suicide, and we believe we have a responsibility as a system of care to do whatever possible to ameliorate that risk in the most clinically sound and financially prudent way possible. Once the crisis passes, more deliberate decisions about what provider is or is not responsible to provide ongoing services can be made with consumer input and with the benefit of a true Diagnostic Assessment. Criteria for ongoing services once the crisis has passed should not be used to manage a current crisis.

We fear that reliance on teams connected directly to Community Service Boards and other core providers can potentially disrupt the separation of function between crisis service delivery and ongoing service provision. In our opinion this leaves the consumer who does not typically have choice without a choice of providers and leaves the crisis system at the mercy of the Core Provider. This effectively eliminates any transparency that this separation of function can provide for stakeholders who are committed to ensuring individuals receive timely access to the appropriate level of care in a timely manner.

For example, should Core Providers be required to provide urgent appointments to Mobile Crisis Response staff, an independent party can ensure an individual is connected to service and not turned away because they do not meet the criteria of the agency or called and rescheduled for a later date. In

our experience an emergency department physician is much more likely to allow an outpatient follow-up in lieu of a 1013 (GA emergency certificate) if the crisis responder can provide an appointment date and time within the appropriate timeframe based on the consumer's acuity and the physician knows that the crisis responder will follow-up and ensure this happens.

Mobile Teams from Private Psychiatric Facilities
Conversion vs. Diversion Rates

Private team assessments in hospitals focus on decreasing ER bed time or increasing their psychiatric inpatient conversion rate or maintaining at a rate that will support the hospital's budgeted average daily census. This rate is calculated by dividing the number of assessments conducted by the number of admissions and represents assessments from these teams "convert" to admission to beds managed by the mobile provider themselves- the proverbial "fox guarding the henhouse." Though these teams can be very experienced and have high assessment volumes, they are designed fundamentally to be an extension of the psychiatric facility's admissions office, and they are charged with admitting individuals they assess with appropriate benefits into the highest level of care for which the consumer meets criteria

Honest Broker Approach BHL's core mission is public sector crisis intervention. We believe that an independent, caring mental health professional can guide a consumer through a crisis without the conflict of interest inherent when managed care companies and behavioral health service providers function in this role. We do not have beds to fill or a payor mix to maintain. Our goal is to refer to the most appropriate service and not to our own and to ensure the individual is firmly in the hands of the provider before we finish the contact.

Crisis Services in the System of Care: The Missing "Link" The System of Care, particularly with regard to crisis, must be creative and innovative. We believe we have demonstrated the clinical acumen, crisis experience, and the ability to coordinate public and private partnerships designed to give communities the tools to care for their own residents using the resources they have without overwhelming any one sector, including resources funded by DBHDD.

While the primary focus of our work is of course the consumer and their families, we think MCRS is often the missing link between BH and IDD providers and "primary customers" including Emergency Departments, Law Enforcement, DHS Child Welfare Workers and Child Welfare Providers, including Emergency Shelters. We believe that as independent, honest brokers, skilled in crisis intervention and supported by real-time information, our MCRS leadership and staff can and have been vital to the execution of an organized crisis response seamlessly connected with multiple parties serving a consumer, ensuring that consumers are firmly connected to the services they need for success, and that all parties are prepared to respond to a future crisis.

Research shows clearly that once individuals are in the emergency department the probability of hospitalization is high. Therefore, BHL focuses on crisis intervention "up-stream" (preferably before someone arrives at the Emergency Department) and works to link individuals to the least intrusive, least costly service that meets the needs of the consumer. Because of the time BHL has put into collaborating

with individuals, natural supports, and community providers, including facilitation of transportation, BHL has achieved phenomenal psychiatric inpatient hospital diversion rates over well over 85%.

After Hours Crisis Response for Consumers Enrolled in Core or Specialty Services We believe that getting the provider of record involved at the time of crisis is paramount. Mobile Crisis will always respond to the crisis as dispatched but will utilize information from the Beacon system to determine enrollment in BH and IDD/Autism services and will use this information to make the best crisis plan possible and coordinate with providers to help keep the individual from being hospitalized or otherwise being placed out of his or her residence. (This speaks to the electronic connection our crisis and access line (call center hub) has with the Beacon ASO in Georgia. Our call takers have enrollment information transmitted from the ASO at their fingertips and this information is used to help determine the provider of record during a crisis.

Since many referrals are initiated by the crisis call center, there has been a strong history of sharing clinical triage summaries with community providers. BHL will send documentation of the crisis intervention triage through electronic transmission. This information is provided at the time of referral to an agency and, with an individual's permission, can be shared with other community providers who may provide follow-up care. BHL's MCID 2020 (Mobile Crisis Information Database) will be used to manage this communication between BHL and Core Providers. We are also looking at automating emails to providers and other aspects of a high utilizer program to share contacts with individuals in crisis with GCAL and or MCRS with the appropriate provider automatically and even in real time with email notifications to appropriate caregivers directing them to life referral status boards when identified consumers are entered in the system. The Georgia Crisis & Access Line staff and BHL's Mobile Crisis Team dispatchers will offer additional support to the interface. We have the capacity with the consumer's permission to give the providers notification emails when one of their consumers is in the ED or being seen by a mobile crisis team

Individualizing the Service to Meet a Geographical Need We have a proven track record of tailoring our processes specifically to meet the needs of the community and to solve specific service delivery problems. Most recently we have partnered with Grady EMS in the City of Atlanta to ride with their staff. With over 300 behavioral health calls a month and many frequent utilizers, we have assisted in cutting trips to the ED for behavioral health issues by 30-50%. We value these community partnerships and are always willing to consider the best way to allocate services to meet a need. We are currently working on two co-responder projects where we are working with law enforcement agencies to help with frequent 911 callers.

Q4. Provide a description of the array of services that could be delivered through your recommended model, including by sub populations (adults, children, mental health, substance use disorder, co-occurring disorders), and if services focus on the immediate behavioral health crisis or address more broad social determinants of health.

CRISIS SERVICES FRAMEWORK BHL operates its mobile crisis teams with the undergirding principles of Crisis Now published by the Crisis Services Task Force of the National Action Alliance for Suicide

Prevention on which Wendy Farmer, BHL's CEO and David Covington one of BHL's owners had the pleasure to serve.

https://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/CrisisNow.pdf

What is Mobile Crisis? According to Crisis Now "Community-based mobile crisis services use face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis, in order to achieve the needed and best outcomes for that individual." We believe that this is the appropriate response no matter the presenting situation which could be related to a behavioral health challenge or a crisis related to a developmental disability or autism spectrum disorder and of course in the case of many situations where there is a dual diagnosis involved.

Goals of Community-based Mobile Crisis Programs According to SAMHSA's recent report on crisis care (2014, p. 10): https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

"The main objectives of mobile crisis services are to provide rapid response, assess the individual, and resolve crisis situations that involve children and adults who are presumed or known to have a behavioral health disorder (Allen et al., 2002; Fisher, Geller, and Wirth-Cauchon, 1990; Geller, Fisher, and McDermeit, 1995). Additional objectives may include linking people to needed services and finding hard-to-reach individuals (Gillig, 1995). The main outcome objective of mobile crisis teams is to reduce psychiatric hospitalizations, including hospitalizations that follow psychiatric ED admission."

According to Crisis Now, "while terms describing mobile crisis care differ, these programs share common goals to:

- Help individuals experiencing a crisis event to experience relief quickly and to resolve the crisis when possible
- Meet individuals in an environment where they are comfortable
- Provide appropriate care/support while avoiding unnecessary law enforcement involvement, ED use, and hospitalization

Crisis Now Task Force Findings on Mobile Crisis Services After reviewing previous reports and research on mobile crisis programs and considering model programs, the Task Force finds mobile crisis services accomplish a wide range of tasks and are a necessary, core component of a well-integrated crisis system of care. To maximize effectiveness, the availability of mobile crisis services should match needs in the area/region they serve on a 24/7/365 basis and should be deployed and monitored by an ATC (Air Traffic Control)-capable regional call center (call center hub).

The Task Force recommended that essential functions of mobile crisis services should include:

- Triage/screening, including explicit screening for suicidality; Assessment;
- De-escalation;
- Peer support;

- Coordination with medical and behavioral health services;
- Crisis planning and follow-up

Triage/Screening (Crisis Now Definition) As most mobile crisis responses are initiated via phone call to a hotline or provider, the initial step in providing community-based mobile crisis services is to determine the level of risk faced by the individual in crisis and the most appropriate mobile crisis team. In discussing the situation with the caller, the mobile crisis staff must decide if emergency responders should be involved.

For example, if the person describes a serious medical condition or indicates that he or she poses an imminent threat of harm, the mobile crisis team should coordinate with emergency responders. The mobile crisis team can meet emergency responders at the site of the crisis and work together to resolve the situation. Explicit attention to screening for suicidality using an accepted, standardized suicide screening tool should be a part of triage.

Georgia has already invested in a strong and standardized screening process through the Georgia Crisis & Access Line (GCAL). GCAL clinicians determine the need for mobile crisis services and the mobile teams are dispatched. A key component of the effectiveness of this system is that in Georgia mobile teams are required to respond immediately to the requests of GCAL and no internal, programmatic screening within mobile crisis teams should take place. When GCAL dispatches the team responds period and this is the expectation for all BHL operated mobile crisis teams.

Assessment (Crisis Now Definition)
The behavioral health professional (BHP) on the mobile crisis team is responsible for completing an assessment. Specifically, the BHP should address:

- Causes leading to the crisis event, including psychiatric, substance abuse, social, familial, and legal factors
- Safety and risk for the individual and others involved, including an explicit assessment of suicide risk
- Strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports
- Recent inpatient hospitalizations and/or current relationship with a mental health provider
- Medications and adherence Medical history

BHL's Proprietary Mobile Crisis Assessment Software empowers Mobile Crisis Team staff to utilize cutting edge assessment tools. [redacted]

MCID is the primary electronic documentation tool used by BHL's Mobile Crisis Teams. [redacted]

The MCRS Clinician enters their information in the MCID Database. Information from this Database is visible to call center agents and stored for immediate and future reference. Clinicians can print the assessment and leave it for professionals on the site of the assessment or to the facility/provider where the individual is referred. Below is the format that prints once the data is entered. They can even desktop fax it to providers if needed as well as upload consent forms and crisis plans using a mobile scanning program. This is all done currently with laptops and wireless air cards. We are currently working on a web platform to allow entry from mobile devices such as iPads and other tablets for the ease of use of our staff in the community.

The collection and understanding of vital medical information is key to good clinical practice. Staff are trained on medical issues to be aware of including the fatal four, signs and symptoms of withdrawal and other medical issues that can manifest themselves in behavior including high blood sugar and stroke.

De-escalation and Resolution (Crisis Now Definition) Community-based mobile crisis teams engage individuals in counseling throughout the encounter and intervene to de-escalate the crisis. The goal is not just to determine a needed level of care to which the individual should be referred, but to resolve the situation so a higher level of care is not necessary.

BHL's mobile crisis teams are trained in de-escalation and using the assessment process itself to help individuals return to a level of pre-crisis functioning. Done well, the intervention itself can diffuse the crisis and make it more likely the individual will be better engaged in ongoing care and services after the crisis intervention. Responders are taught about the power of active engagement and collaborative problem solving and these techniques, with a strong crisis intervention research base, are utilized along with expert risk assessment, a level of care assessment and an attempt to give the individual a choice of services for ongoing care whenever possible. This is all accomplished while working to keep family and other caregivers engaged in the process and even separating the caregiver from the individual briefly to allow private conversation when warranted.

All staff are trained in supportive counseling techniques that include active listening, psychoeducation, and working with natural supports to identify the strengths, needs, abilities and preferences of the individual. The teams are constantly trying to find ways to remove stressors, utilize the individual's strengths and preferences to diffuse the crisis and engage those the individual wants involved in their care to bring comfort and stability to the situation and environment. With data back to 2006, GCAL is a

tremendous resource as past crisis situations can shed a lot of light on current ones and documentation can help us determine what helped and what hurt during the last crisis response.

Risk assessment and mitigation is key to the interaction. All staff are trained in CALM (Counseling on Access to Lethal Means) and taught about having vital conversations with individuals and their caregivers on the importance of removing lethal means from the environment.

Formal training on crisis intervention is also essential. An important part of providing crisis services is being able to help de-escalate crisis. The Crisis Prevention and Intervention (CPI) training on de-escalation (a 16-hour training) or Crisis Intervention Training, which is completed by all staff, are the primary trainings provided, and include not only verbal de-escalation, but other techniques to defuse a crisis. These techniques include, but are not limited to, the use of comfort foods, gliders/rockers or music, which can elicit soothing feelings; allowing the person in crisis to have safe, alone, quiet time; empathy and reflection; and problem-solving during immediate crisis. Crisis team members are also taught to recognize signs and triggers that could cause an explosive episode and how to respond to aggressive behavior. Through CPI training or CIT, mobile team staff are taught how to verbally de-escalate rising aggressive behaviors, and how to most effectively respond to each behavior to prevent the situation from escalating. Staff can effectively use verbal and non-verbal techniques to defuse hostile behavior and resolve a crisis before it becomes violent. Mobile team staff is also taught the Principles of Personal Safety to avoid injury if behavior becomes physical.

If, during mobile crisis activities, it is determined that an individual needs off-site based support services, the mobile crisis team will be able to refer to needed interventions to decrease aggression, including referral to more intensive BH and DD services (same or next day appointments are available), crisis homes, and crisis stabilization units.

However, if during assessment if is determined that on-site support is more appropriate given all variables, the mobile team is able to make referral for in-home therapeutic support services for the caregiver and the individual. After triage, screening and assessment have been completed, the crisis team will work with the individual, his or her caregivers and other supportive individuals, and with existing providers to assess ongoing needs to prevent future crisis. However, if during mobile crisis assessment it is determined that the interventions required are a change or addition of ongoing services for the individual (i.e. day treatment, community living service, community access individual, or community access group), a different residential setting (community residential alternative), or respite placement; the mobile crisis team will contact the assigned Planning List Administrator or Support Coordinator listed in CIS/Beacon Case Management System to make these recommendations known.

We also work with a goal of avoiding law enforcement intervention or emergency department intervention whenever possible. GCAL dispatch levels, authored by BHL in several iterations over the years are utilized to ensure safe response and to reduce reliance on law enforcement. Only a very small number of dispatches involve police intervention (5-7% on average). While call center and mobile crisis staff are trained to work with police collaboratively in situations that call for their intervention and police intervention can be engaged at any time during the intervention, all BHL staff are trained to work

diligently to avoid this if possible. If law enforcement must be engaged to ensure the safety of the individual, the care givers or the responders, CIT officers are requested and BHL staff fully inform dispatchers and responding officers about the situation and what is needed from law enforcement at the time. Efforts are made to ensure the clinician has as much "command" of the situation as possible and law enforcement is asked to engage for specific purposes with clear instruction about what is needed and what isn't.

If it becomes clear to the team at any time that emergency room intervention may be necessary, there are protocols in place. If 911 must be called, we take the same approach as we do with law enforcement and try to minimize the chaos and attempt to prevent any stress for the individual or caregiver. Staff however do not hesitate to call 911 if it is medically necessary but if it is not a 911 situation and there is discussion of utilizing an emergency room for any reason, mobile responders are required by protocol to contact a mobile crisis supervisor for consultation. The goal is to resolve the crisis in the individual's environment if possible.

Peer Support (Crisis Now Definition) According to SAMHSA (2009, p. 8), mental health crisis services "should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand. In addition, peers can offer opportunities for the individual to connect with a supportive circle of people who have shared experiences—an option that may have particular relevance given feelings of isolation and fear that may accompany a mental health crisis" For community-based mobile crisis programs, including peers can add complementary qualifications to the team so that individuals in crisis are more likely to see someone they can relate to while they are receiving services. Peers should not reduplicate the role of BHPs but instead should establish rapport, share experiences, and strengthen engagement with individuals experiencing crisis. They may also engage with the family members of (or other persons significant to) those in crisis to educate them about self- care and ways to provide support.

At BHL, certified Peers are involved whenever possible in the intervention and involved in all follow up contacts. BHL MCRS strives to instill hope that recovery is possible and demonstrates its commitment to recovery in the following ways:

Peer Support: the power of peer support has been woefully underestimated in behavioral healthcare programs and this is especially true in our experience in crisis programs. BHL utilizes peers as care navigators and they are an essential part of our mobile crisis response services. Peer are responsible for engaging individuals in ongoing care and to give them tools to facilitate the process. Our Care Navigators are also responsible for ensuring crisis responders are walking the walk when it comes to principles of recovery give the team invaluable input before during and after crisis situations.

Self-Directed- Individuals and those who care for them are the "experts" when it comes to themselves and their recovery needs. While we are highly trained professionals with significant crisis experience, we never lose sight of the importance of the ability of individuals to direct their recovery path- even in times of crisis. We are facilitators charged with ensuring individuals are safe during a crisis, but our

primary role is advocating with the person and their loved ones for care that meets their needs while respecting the individuals own recovery path.

Individualized and Person Centered- Collaborative problem solving and active engagement are fundamental components to our crisis services. Engaging an individual in care is best accomplished by joining with the person (collaborating) to identify the problem and to generate ideas for how it can be resolved. A one-size fits all assessment and referral process does not take the time to engage the consumer but rather relies on observations and decisions made by an "expert." Individuals are much more in tune with goals that they identify themselves and more likely to take advantage of and benefit from services that respect their unique ways of accomplishing those goals while utilizing their unique resources or strengths related to their cultural background, their history and their recovery experience to support them in the process.

Choice- Our mission is to intervene in times of crisis, engage consumers in care, and provide linkage to life-saving services- not to our own. We don't have a census goal to meet, beds to fill, or payer mix to maintain. The conflict of interest inherent when providers operate crisis services does not apply. We exist solely to be clinician advocates- dedicated to assessing needs objectively, linking individuals to services of their choice, and in doing so, fostering recovery and ultimately responsible stewardship of public funds.

Holistic- Because Mobile Crisis Response services are offered in the community, often in the individual's home or residence, our teams have a unique opportunity to help consumers identify and rally their natural supports and other unique resources to support them during a crisis. Our teams look at the whole picture- mind, body, and spirit. Assessments, referrals and interventions are chosen specifically to best utilize the individual's natural supports while respecting their physical, spiritual, and emotional needs as well as their own goals for living, learning, working, and socializing.

Non-linear- "A Crisis Has No Schedule" and neither does the recovery process. Our goal is to instill hope that recovery is possible for individuals even when things look grim or when the world seems to be falling apart around them. Our Assessors are knowledgeable about the recovery process and how unique the path is that each individual takes. We know that setbacks are a "normal" part of recovery and do our best to "normalize" experiences that feel anything but "normal." All is not lost when a crisis occurs. By focusing on strengths and giving recognition to individuals every bit as much for recognizing a crisis as for climbing out of one, our Responders strive to instill hope that can be lost in times of stress.

Strengths Based- While assessment of risk is key, our teams are also looking for individual consumer strengths to mitigate this risk. We listen to the consumer and help them identify the strengths they already have and assist them in utilizing these strengths to sustain them through the crisis. We don't dwell on what if anything led to the individual getting of track. Our staff members are truly in awe of the strength of these everyday heroes and make sure to remind individuals of the incredible strength and resiliency it takes to get back on that road to recovery.

Respect- Individuals in need of behavioral health services have long been denied respect from their communities and even their families. Stigma regarding behavioral health problems is unfortunately

palpable in the healthcare system as well. Some healthcare providers even believe individuals with behavioral health issues have disordered character or choose the situation they are in. We never lose sight of this unfortunate truth and work hard to instill recovery principles in our employees across the entire business. Advocacy initiatives take center stage at BHL and leaders are dedicated to our services combating stigma.

Responsibility- Individuals have long been left in the waiting room while their treatment is discussed and planned by "experts" treatment team meetings. Our goal is to involve the consumer and others they choose to be involved in the process of caring for them. Self-care is paramount and recovery takes tremendous courage. Recognizing that individuals are indeed resilient and allowing them to use their inner strength to care for themselves and take responsibility for their recovery process.

Hope- Our team strives to instill hope that recovery is possible. Celebrating successes, even small ones, is crucial to giving individuals motivation to overcome the obstacles before them. We are there in times of crisis to remove as many obstacles as possible so the individual can put his or her energy into their recovery process. The way we treat individuals in crisis is vital to this success. We teach our staff that while crisis can become routine to a crisis worker, they must remember that no matter how stressful our day has been, the folks we serve are quite possibly having the very worst day of their lives and deserve our full attention and support and we can serve as a reminder that tomorrow can be a better day.

Coordination with Medical and Behavioral Health Services (Crisis Now Definition) Community-based mobile crisis programs, as part of an integrated crisis system of care, should focus on linking individuals in crisis to all necessary medical and behavioral health services that can help resolve the situation and prevent future crises. These services may include crisis stabilization or acute inpatient hospitalization, treatment in the community (e.g., CMHCs, in-home therapy, family support services, crisis respite services, and therapeutic mentoring).

Holding the individual's hand until safely in the hands of another: Asking for help takes courage. Being that helping professional at the front door to care is an awesome responsibility and one we don't take lightly. While crisis may be somewhat "routine" to us, we work hard for our staff to recognize that though they are specially trained to mitigate crises, the moment in time when individuals are engaging our help is quite possibly one of if not the worst day of their lives.

In Georgia, once completing the assessment, the procedure with many mobile teams, particularly those who work out of Emergency Departments is to call GCAL for "placement." While our call center often assists in referrals, it is clear that our Mobile Crisis Response Staff are to hold the hand of that consumer until they are safely in the hands of a provider or caregiver. Our real-time data tracking tools are designed specifically to ensure we have followed the individual until they no longer need our assistance. Equipped with the best available information in real-time, BHL teams' direct access to data ensures the best connection possible with ongoing care and services.

Connectivity with Community Providers: BHL Mobile Crisis Teams identify the level of need of the individual in the current crisis situation and using LOCUS/CALOCUS Patient Placement Criteria and make a recommendation about the level of intervention necessary to meet the individual's needs:

If the BHL Mobile Crisis Team determines after assessment that the individual is in need of routine services, we work with providers so staff has real-time access to scheduling appointments with community mental health providers through a web-based software system. This access allows immediate scheduling for appointments no matter the day or time.

For individuals in need of urgent care, staff assesses the individual's current provider status and assess the potential for using current community resources to help manage. If the individual is not currently in services with a mental health provider, staff may consider a referral for urgent care in an outpatient setting.

When individuals need emergent services, BHL works closely with the first responder networks in local communities. BHL will secure Memorandums of Understanding with the 911 providers in many areas of the State and will collaborate with the emergency services in all service regions for additional partnerships. Additionally, BHL will work closely with local law enforcement in all parts of the State and will continue to support and work with CIT programs, including participating in training for local CIT.

Crisis Planning and Follow-Up (Crisis Now Definition) SAMHSA's essential values for responding to mental health crisis include prevention. "Appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse. Hence, an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvements" (SAMHSA, 2009: p. 7, emphasis in the original). During a mobile crisis intervention, the BHP and peer support professional should engage the individual in a crisis planning process, which can result in the creation or update of a range of planning tools including a safety plan. When indicated, they should then follow up with individuals to determine if the service or services to which they were referred was provided in a timely manner and is meeting their needs.

BHL Crisis Planning and Follow-up- If the individual already has a crisis plan, WRAP (Wellness Recovery Action Plan) or behavior support plan, our first goal will be to ensure the safety of the individual through use of the plan already in place and our teams will be equipped with the electronic access necessary to access needed information in real time. Below is a screenshot of the current BHL Mobile Crisis Safety Plan utilized during behavioral health mobile crisis response.

The blended mobile crisis team understands that when an individual with IDD or ASD is engaged in the active, disruptive stage of a behavior, such as a tantrum or aggression, the essential focus must be on the safety of the individual, those around them, and the protection of the property. It is noted that when an individual is in full crisis mode, they are incapable of reasoning, being redirected, or learning replacement skills. If there is a crisis plan already in place, the team works with care-givers to implement the strategies described in that plan. If a plan has not yet been developed, the mobile crisis team assists caregivers and the individual in anticipating these behaviors and preparing for the situation and creates a crisis plan.

The crisis plan includes:

- Defined setting events, triggers or signs that a crisis situation might develop
- Tools and strategies for keeping the individual and those around them safe in any setting (school, homes, community)
- Intervention steps and procedures promoting de-escalation that are paired at each level with increasing levels of agitation
- List of things to do and not to do specific to the history, fears, and needs of the individual
- Hands on training and practice for caregivers and staff
- Data collection and monitoring (if necessary and appropriate) for continued re- evaluation of the effectiveness of the plan
- Knowledge of the best prepared facility if an out of home placement is absolutely necessary

A Note about Emergency Room Response: The final disposition for an emergency room based mobile crisis response is the final decision of the attending emergency room physician and no dispositions are recommended to the individual or family without consultation with and agreement from the emergency room physician which is why the physician must sign the plan. BHL Clinicians also do not write 1013/2013 (transportation orders for involuntary evaluation in Georgia) forms inside emergency departments. While a BHL Clinician may recommend that one be signed or that one be rescinded, this is the sole responsibility of the attending physician. If there is a significant clinical disagreement about what is in the best interest of the consumer and the consumer is under the care of an emergency room physician, BHL's Chief Clinical Officer and Medical Director will become involved and will be asked to consult with the attending physician to work towards resolution.

Mobile Crisis Follow-up- BHL makes an initial effort at follow-up on all face-to-face services within 24 to 48 hours, depending upon the level of service and need of the individual. When an urgent next-day outpatient appointment is required, MCRS staff will follow-up with the provider agency to ensure services were accessed, and with the individual to gauge their status. Upon request, the individual served or their legal representative may receive a written summary of the crisis contact and referral(s) which includes: 1) identified needs, 2) level of care recommendation and 3) referral information. In Georgia we also submit a full report in an automated fashion to the CMO for any enrolled individual.

Mobile Crisis Clinicians are responsible for follow-up by contacting the individual (and referral organization, if applicable) to assure they have received necessary services or to ascertain the final disposition of a crisis intervention contact. We have automated documentation of this process in our MCID/DMS 2018 (Dispatch Monitor System). This software automation ensures staff follows strict protocols and that no individuals are missed. These attempts at follow-up are also made for individuals for whom a referral to Mobile Crisis Team services is made but who are not seen (leave the premises, refuse interaction, etc.).

Q5. Describe the expected ratio of services in this model of face-to-face versus phone or in-office contacts. New Hampshire Department of Health and Human Services Statewide Mobile Crisis Response Teams Page 8 of 14 RFI- 2020-DBH-01-MOBIL.

Currently about 12.5 percent of calls to the crisis call center result in mobile crisis dispatches in Georgia and the teams are expected to respond to 100% of them face to face- no questions asked.

Q6. Provide a description of how this model will successfully deploy mobile crisis services in both densely populated and rural regions within a designated timeframe, such as one-hour.

In Georgia we utilize proprietary GPS enabled dispatch software. [redacted] The video linked below describes our GPS enabled software utilized for dispatch.

https://www.youtube.com/watch?v=UVHUhge9YoQ

Q7. Describe how this model will utilize best practices to meet the needs of currently underserved populations including people who identify as Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ); transitional age youth and young adults; pregnant women with behavioral health conditions; and racial, ethnic and linguistic minorities.

Mobile Crisis almost by definition implies individualized service delivery. The goal is to see the individual in their environment of choice as quickly as possible, to mitigate the crisis or prevent crisis escalation as quickly as possible and to ensure the individual has access to needed resources of their preference as quickly as possible, as close to home as possible and in the home or environment of choice if at all possible. We of course have a contract with the Language Line and utilize it as needed. We also work closely with DBHDD Deaf services and engage DBHDD trained interpreters whenever possible.

It is important to understand that the accreditation requirements under which BHP operates (CARF, AAS (American Association of Suicidology, and NADD) and our training curriculum ensure that we emphasize not just individualized care, but individualized crisis care for each individual and family we serve.

BHL has a strong commitment to meeting the individual needs of those who utilize the company's services. All staff receives Cultural Competency training including sensitivity training related to the needs of various populations. This training focuses on the understanding of disabilities, views and perceptions, and positive or negative experiences with the disability. Included in this training is a systems perspective of families and service providers, extended social supports networks and most importantly consumers themselves. Age specific competencies are taught as well as cultural competence specifically designed for crisis workers.

To do this work, BHL mobile crisis teams receive initial and ongoing training and supervision related to providing specific crisis care to individuals. Not only are they trained as all clinicians are required to be

with basic cultural and linguistic competence curriculum information, they are trained specifically in risk formulation and crisis intervention with specific groups including but not limited to:

- Children
- Transitional Youth
- Adults
- Older Adults
- Ethnic and minority groups
- LBGTQ
- Disability Specific (Mental Health, Substance Use Disorders, Intellectual and Developmental Disability, Autism and Dually Diagnosed)
- Individuals with histories of trauma and abuse/neglect
- Deaf & Hard of Hearing
- Physical Disabilities
- Individuals who are incarcerated

As a crisis center accredited by the American Association of Suicidology, BHL is held to vigorous standards regarding specific cultural competencies specific to the arena of crisis intervention and suicide prevention. Below is a sampling of excerpts from AAS Fact sheets used for staff training. AAS gives us access to a wide-variety of educational tools. We use similar resources for crisis intervention/suicide prevention related cultural competence for age related competencies, competencies related to race and ethnicity and disability.

In short, our commitment to cultural competence doesn't just rely on generic training. Our commitment to cultural competence is very specific to appropriate crisis response, risk assessment and crisis intervention with individuals with differing needs.

BHL has also achieved NADD accreditation and will have our staff certified to respond to individuals with dual diagnoses (BH/IDD). Parallel to the NADD accreditation process, key staff members from each program will be receiving NADD certification training: Clinical frontline staff will receive the NADD Competency-Based Clinical Certification which teaches best practices on how to intervene with dually diagnosed individuals; Trainer's/Managerial/Supervisory staff will complete the NADD Competency-Based Dual Diagnosis Specialist Training which teaches best practices for leading and directing staff who provide services for the dual diagnosis population; and Bachelors level staff and Peers (secondary responders)will complete the NADD Competency-Based Direct Support Professional Certification which teaches non-clinical frontline staff best practices to support and interact with this population. By the end of 2018, BHL not only expects to be NADD accredited, but will have a minimum 5% of its staff and leadership NADD certified. The 5% staff certification is an interim goal on the way to having a minimum of 10% of staff trained which is a NADD requirement. Our goal over time would be to see this as high as 33% of the BHL team specifically certified for dual diagnosis care.

Q8. Include a description of any efficiencies that may be gained through the model.

Effective Mobile Teams should stabilize between 70% and 75% of the persons that they see. These outcomes decrease the need for ED visits and the over-prescription of inpatient psychiatric hospitalization.

Q9. What other relationships or partnerships would support the implementation of this model? Include a description of both the role partners would play in program implementation/operations and financial sustainability. (Examples of partnerships include law enforcement, hospitals, and/or first responders.)

In our experience, between calls, these teams should be building relationships with first responders, emergency departments and providers. Our teams host quarterly crisis collaboratives in their service areas where they discuss pain points in the system, data, performance and talk through challenging situations to problem-solve solutions. We also serve as the local suicide prevention experts and provide ASIST and Safe Talk training to the community. We also assist with postvention in the event of a suicide and disaster response if there is a need for critical incident response in the areas we serve.

Q10. Provide an overview of the technology and infrastructure needed to support this model. GPS enabled tracking and dispatching is a must.

BHL currently utilizes proprietary dispatch software in the crisis and access contact center (Call center hub) and locally with the mobile crisis teams.

BHLGo developed by BHL, this suite of programs contains everything needed to dispatch, track and communicate with mobile crisis teams.

Call Center Dispatch In Georgia, BHL can track all mobile crisis team locations Statewide. Georgia requires that all mobile crisis teams are dispatched by the BHL call center. Call takers identify responsible teams based on the location of the individual in need. Once they click dispatch, the clinical triage is sent via encrypted email to the dispatched team. The team goes into our secure website with a smart phone, tablet, or laptop and accepts the dispatch. This starts the transit time.

Once arrived on the scene, the team again access our mobile application, and this stops the transit time and calculates the response time. The time on scene is also calculated as well as all state required reporting elements at the end of the call. The dispatch monitor information is viewable at any time by the individual teams (each team can see their own dispatches) and the funder. State staff with appropriate access rights can see teams by region, multiple regions or even statewide data in real time. Clicking on the individual case brings up the clinical data from the call center. Aggregate dispatch information from the dispatch monitor is pushed into a live dashboard.

GPS Enabled Tracking for Local Teams In Georgia we utilize proprietary GPS enabled dispatch software locally with the teams. [redacted]

[redacted]

Real-time Electronic Documentation Our mobile teams document assessments and interventions in real time utilizing proprietary software on tablets or laptops. They can desktop fax referrals right out of the living room if needed.

https://www.youtube.com/watch?v=UVHUhge9YoQ

Q11. Provide a description of step-wise options to implement the proposed model(s). Include specifics regarding hours of operation and provision of services to all geographic regions.

BHL has experience with large scale implementation specifically related to crisis services and mobile crisis services. In January of 2019, we successfully staffed and implemented 24/7 blended mobile crisis for adults and children with mental health substance use and developmental disability related crises in 64 new counties covering over 22,000 square miles and a population of 2.74 million with a 6- week implementation period post award.

BHL has repeatedly demonstrated an ability to implement large projects in collaboration with Georgia DBHDD and bring them to scale quickly. In 2005, DBHDD initially approached BHL for the crisis/access component of a FEMA Crisis Counseling Program disaster response following Hurricane Katrina. However, within weeks Georgia DBHDD had engaged BHL to provide mobile outreach and engagement across 90 Georgia counties.

In 2006, the original plan was for a 90- day implementation for the Georgia Crisis & Access Line. The company received official notification only five weeks prior to the launch and yet answered more than 21,000 calls during the very first month. This approach has also been true with our Mobile Crisis implementation experience. When BHL started Mobile Crisis in Region 1 in 2007, we exceeded contract deliverables in the very first month and we had no delays with the implementation of Regions 3 and 5mobile crisis for a population of 4.33 million in 17,161 square miles in 2013 when we were also on time and within budget.

Q12. Provide details on the required team composition needed to deliver the scope of services proposed in your model, including staff competencies, areas of expertise, and specialty training requirements.

Two staff is the preferred staffing model. This should be one licensed clinician and one paraprofessional (BHT or Peer). Training should include: Risk assessment, community resources, engagement strategies, personal safety considerations, electronic health record, legal considerations and ethics.

Training should also include non-violent crisis intervention, de-escalation, means restriction, medical necessity criteria for detox (clinicians need to understand withdrawal fully and be able to ensure individuals experiencing life-threatening symptoms of withdrawal are treated quickly), TIP 42- Rapid

Crisis Screening, behavior support principles, trauma informed care, cultural competence, lethality assessment, suicide statistics and myths and person centered approaches to care.

Q13. Describe any challenges that need to be considered under this model.

Workforce considerations are paramount. Georgia currently requires on fully licensed clinician on all responses and this is challenging in rural areas in particular. We caution those making staffing decisions carefully review workforce considerations in all service areas before determining credentials for teams. In our experience associate licensed staff are sufficient under supervision and with access to fully licensed staff via telemedicine if an emergency certificate must be signed. This is also a great way to "grow" a crisis trained workforce.

Q14. Describe any required data collection measures needed to address the effectiveness of these services.

Multiple Key Performance Indicators are useful. Absolutely required is average response time, time on scene and community stabilization rates. Additional metrics to evaluate include percentage of calls to and from law enforcement as well as rates of involuntary commitment by MCOT team members.

We would recommend adjusting diversion rates for mobile assessments in ERs. The individual is much more likely to be hospitalized if the ER doc has seen them. Even though mobile teams do a great job talking docs out of unnecessary hospitalizations it is still much more likely the individual will end up in the hospital just because he or she made it that far) therefore diversion rates in ERs are traditionally lower than those of interventions taking place further upstream i.e. in the home or school.

Q15. Describe the preferred tools to be used with the specified populations, including adults, children and youth who have suicidality, violence, mental illness, SUD, and cooccurring disorders. Describe potential tools used for assessing additional vulnerabilities including economic, physical environment, education, food, social context and healthcare (Social Determinants of Health).

Standardized risk assessment tools to include the Columbia Scale should be utilized. We recommend that the teams be accredited by CARF, AAS and NADD. Staff should be well versed in ACES. Though we don't administer the scale in a crisis situation, it is important for crisis responders to be fully aware of the impact of adverse childhood experiences.

Q16. In your estimation, how much money will it cost to provide a fully integrated statewide mobile crisis response teams and how many individuals would your organization be able to serve? You may provide estimated cost information in any format. If helpful, use the table below to consider the kinds of costs to include. Please include costs expected to be associated with standing up and sustaining the recommended model. New Hampshire Department of Health and Human Services Statewide Mobile Crisis Response Teams Page 9 of 14 RFI- 2020-DBH-01-MOBIL Type of Cost Estimated Cost Explanation of Costs Start Up Costs (e.g. planning, training, and/or infrastructure) Directs Costs to provide mobile crisis response services to individuals Indirect Cost to support effective organization (e.g. facilities, leadership, staff, functions shared across your organization) Anticipated # of individuals to serve per year for this cost

This will depend on multiple factors including whether teams will be required to bill third parties (Medicaid, private insurance etc.) Based on our current operations in a region of Georgia with roughly the same geography and population density our estimate is the following:

Implementation- [redacted]

Administrative Overhead- [redacted]

Personnel Services- [redacted]

Per Diem/Contracts- [redacted]

Transportation- [redacted]

Other Direct IT/Supplies- [redacted]

Total Estimate for Implementation and First Year of Service: [redacted]

The number of individuals served is very difficult to predict with capacity funding, the state of New Hampshire can expect that teams respond to all requests. Based on a similarly sized region in Georgia (DBHDD Region 6 with a population of 1.41 million covering 9,876 square miles, we currently see about 3,000 individuals a year).

Q17. Provide a recommendation of funding model(s) to support the ongoing delivery of services associated with this model. Models may be, but are not limited to, a daily rate for a total cost; bundled service rate (identify which services), administrative rate/costs that pass to providers, and/or tiered Medicaid rates. In addition, what type of funding sources are available such as private insurance, Medicaid, general funds, etc.?

These services must be considered an essential service and be funded to support sustainability. In Arizona, this service is a Medicaid reimbursable service. It is billed under code H2011 with the HT modifier for a two person team. In general, these services work well in a block purchase contract based on costs matched up to encounter value.

In Georgia the state funds mobile crisis capacity. Georgia is not an expansion state and though we submit encounters for data tracking purposes, DBHDD funds mobile crisis on a 1/12th payment mechanism.